THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER
AT HOUSTON

UTHSC MRI Center
6431 Fannin, G.605 Houston, TX 77030
Tel: (713)500-6916 Fax: (713)500-0698

EXAMINATION ORDER FORM

SCAN TIME/DATE: _____ NAME (Study name or Code number): _____

PATIENT NAME: _____ PT ID# _____

PATIENT D.O.B.: _____ AGE: _____ GENDER: MALE FEMALE

PATIENT IS: RIGHT HANDED or LEFT HANDED HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: Beauchamp PHONE: x5978 FAX: _____

DIAGNOSIS: N/A

PLEASE CHECK EXAM REQUIRED BELOW

MRI of Head & Neck

_____ Temporomandibular Joint
_____ Orbits/ Face/ Neck
_____ Head, Attention to IACS
X Brain Without Contrast
_____ Brain With & Without Contrast*
_____ Pituitary With & Without Contrast*

MRI of Spine

_____ Cervical Without Contrast
_____ Cervical Spine With & Without Contrast*
_____ Thoracic Without Contrast
_____ Thoracic With & Without Contrast*
_____ Lumbar Without Contrast
_____ Lumbar With & Without Contrast*

MRI of Extremities

_____ LEFT Knee
_____ RIGHT Knee

MRI of Abdomen & Pelvis

_____ Abdomen
_____ Pelvis

MRA

_____ Head
_____ Neck

REQUIRED INFORMATION FOR ALL CONTRAST ORDERS:

- Contrast Injection X 1 dose via IVP / Injector (dose 0.2ml/kg with Max dose of 20ml)
- Patient who has a history of Diabetes Mellitis and/or Renal disease will need a STAT Creatinine done (if no serum creatinine has been performed in the last 2 weeks.)

MD Signature: _____ Date: _____

Special Instructions: _____

PRIMARY INVESTIGATOR SIGNATURE: _____

ACCOUNT NUMBER FOR CHARGE: 02-25520000-50000-7425-13

Rev. 09/15/08